

Waiting List Exception Request

Date:						
Client N						
S#:	DOB:		Tier:			
CM:		TCM Phone:				
/ledicai	•	plication:				
not el	igible for Medicaid, please explain why:					
1.	Which crisis definition applies to this situation? (Please m					
	Requires protection from confirmed abuse, neglect, or exploitation or written documentation of pending action for same (Please provide supporting documentation)					
	Perram Q access to cause (, reace browned on blow m Q ac					
	DCF currently involved?	□ Yes	□ No			
	Police/Court currently involved?	🗆 Yes	🗆 No			
	Medical Specialist currently involved?	🗆 Yes	🗆 No			
2.	Are there current significant Behavioral/Mental Health Ne Explain:	eeds?	□ Yes	□ No		
	Are Behavioral/Mental Health Services in place?		□ Yes	🗆 No		
	Provider :					
	Services:					
	Is there a current Behavioral Support Plan?		□ Yes	🗌 No		
	Are these needs being met? If not, why:		🗆 Yes	🗆 No		
3.	Are there current significant Medical Needs? Diagnosis		□ Yes	🗆 No		
	Are these needs being met? If not, why:		□ Yes	🗆 No		
	Can these needs be met through EPSDT? If not, wh	y:	□ Yes	🗆 No		

4. What Services are being requested:

IN-HOME SUPPORT				
What are the current support system				
 □ Parents at home □ Parents c □ Friends □ Church 	-		•	
☐ Friends ☐ Church ☐ Medical Supports (in home care/l	□ Family			
			unded Support:	
Are In-Home Support current		\Box Yes	□ No	
Who is the provider:				
What has changed:				
what has changed.				
DAY SERVICES				
What are the current day activities:				
□ School/Education	🗆 Employment	🗆 Volunteer Oppor	Volunteer Opportunities	
Mental Health Services	Medical Services	🗆 Private Pay I/DD	Private Pay I/DD Services	
Recreational Activities	□ Other:			
Are Day Services currently be	ing provided:	□ Yes	🗆 No	
	01			
What has changed:				
Have employment options be	an avalarad2 If not why:	🗆 Yes	🗆 No	
Is there an open Vocational F	Rehabilitation case?	🗆 Yes	□ No	
RESIDENTIAL SERVICES				
What are the current living arranger	nents:			
Lives in own home alone	\Box Lives in own hom	ne with others		
□ Lives with parents/family/friend	Homeless			
Lives in foster home placement	•	setting/nursing home		
Other:				
Does the individual currently have al	pility to pay room and board?	□ Yes	🗆 No	
If not, why:		When:		
Why are current living arrangement	s no longer able to meet the ne	ed.		
Terminally ill/significant health iss	-	cu.		
□ Confirmed for abuse, neglect or e	xploitation			
□ Placed in nursing facility/assisted	-			
□ Incarceration				
\Box No longer willing/able to provide :	supports			
□ Inability to continue private pay s				
□ CDDO no longer able to fund supp	oorts/services			
□ Other:				

5. What other community resources have been explored prior to making this request (Check all that apply)?

Other HCBS Waivers	\Box Mental Health Services	Parsons Outreach Team
MCO Value Added Benefits	Local Family Support Grants	🗆 EPSDT
Private Insurance	🗌 Vocational Rehab	DCF Programs
Educational Programs	🗌 After School Care	🗌 CDDO State Aid
Independent Living Skills Services	Other:	

6. Persons living in the home:

Name	Relationship	Age	Employed	

7. Gross Monthly Income:

SSI/SSDI	\$ Employment	\$
Family Support/Subsidy	\$ Alimony/Child Support	\$
Cash Assistance	\$ Trust Fund Payments	\$
Adoption Subsidy	\$ Food Stamps	\$
Other	\$ Explain Other	
	Monthly Income	\$
	Annual Income	\$

8. Gross Monthly Expenses:

Mortgage/Rent	\$ Electric/Gas	\$
Phone	\$ Cable	\$
Water/Trash	\$ Alimony/Child Support	\$
Food Transportation (payment, gas,	\$ Laundry	\$
insurance)	\$ Childcare	\$
Insurance	\$ Savings	\$
Retirement/Investments	\$	
Other	\$ Explain Other:	
	Total Monthly Expenses	\$
	Annual Expenses	\$

9. What is the immediate negative outcome if the service is not approved?

10. Please summarize the request for exception with any additional detail the funding committee should be aware of related to this request? This includes any barriers to placement (family, financial, behavioral)

I ______ authorize my case manager to submit this request for funding

(person/guardian)

to the CDDO & Kansas Department for Aging and Disability Services. The CDDO of Butler County will review the request and supporting documentation within 3 business days and determine if all other community supports have been exhausted prior to making a possible recommendation to KDADS.

If/When the request is forwarded to KDADS, they have 10 business days to follow up with additional questions and make a determination on the exception to services. If KDADS has determined an approval to bypass the waiting list and access I/DD Waiver Services, they will inform the parent/guardian via mail.

The Managed Care Organization (MCO) managing the Medicaid Card will contact the parent/guardian to complete a Needs Assessment to determine the HCBS services which will be approved. Once services have been approved, the parent/guardian will need to contact the CDDO of Butler County to complete Options Counseling/Provider Choice choosing the providers in our area for the services.